

# SMALL EMPLOYER GROUP OPTIONS ENROLLMENT FORM



550 12th Street, SW  
Washington, D.C. 20065

## 1 EMPLOYER INFORMATION

Employer/Group Administrator _____	Group Numbers: BlueChoice _____ Dental _____
Effective Date Requested __ __ / __ __ / __ __	Vision _____ Other _____

Check all that apply: Employment Status:     Active     Retired     Full Time     Part Time

## 2 TYPE OF REQUEST

<input type="checkbox"/> New Subscriber <input type="checkbox"/> Coverage Change <input type="checkbox"/> Add Dependents <input type="checkbox"/> Delete Dependents <input type="checkbox"/> Any information change (name or address change)	Are you enrolling eligible dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No
---	--

## 3 COVERAGE LEVEL

<b>Coverage Level:</b> <input type="checkbox"/> Individual <input type="checkbox"/> Parent and Child <input type="checkbox"/> Husband/Wife <input type="checkbox"/> Family	<b>Coverage Selected:</b> Check only those options that your employer has elected to offer. <input type="checkbox"/> BlueChoice <input type="checkbox"/> BlueChoice Opt-Out <i>Plus</i> <input type="checkbox"/> BlueChoice Opt-Out <input type="checkbox"/> Dental HMO <input type="checkbox"/> Dental HMO Opt Out
--	--

## 4 SUBSCRIBER INFORMATION

Social Security Number __ - __ - ____	Subscriber Last Name	First Name	Middle Initial
Date of Birth __ / __ / __	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Hire: __ / __ / __	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed Effective Date of Marital Status __ / __ / __
Street Address _____		Apt. _____	City _____ County _____ State _____
Country _____	Zip _____	Home Phone ( ) _____ - _____	Work Phone ( ) _____ - _____

## 5 SUBSCRIBER & DEPENDENT INFORMATION - Please list all persons to be covered.

List the primary care physician for each person and indicate if that person is currently a patient of that physician.

Last	First	MI		Relationship	Sex	Date of Birth	Social Security Number	Existing Patient	Disabled *	Student *	Primary Care Physician	PCP ID Number	Dental PCP	PCP ID Number
			<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Change	Subscriber				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				
			<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Change	Spouse				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				
			<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Change	Dependent				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				
			<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Change	Dependent				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				
			<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Change	Dependent				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				
			<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Change	Dependent				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				

**\*If yes, disabled, please attach disability certification form and supporting documentation.**

**\*If full time student, please attach student certification form.**

## 6 MEDICARE INFORMATION (To be completed if applicable.)

Are You Eligible for Medicare?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare Number If Yes: __ - __ - ____ - ____	Hosp. Eff. Date (Part A) __ / __ / __	Med. Eff. Date (Part B) __ / __ / __
Reason for Entitlement: <input type="checkbox"/> Age 65 or older <input type="checkbox"/> End Stage Renal Disease <input type="checkbox"/> Disabled				
Spouse?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare Number If Yes: __ - __ - ____ - ____	Hosp. Eff. Date (Part A) __ / __ / __	Med. Eff. Date (Part B) __ / __ / __
Reason for Entitlement: <input type="checkbox"/> Age 65 or older <input type="checkbox"/> End Stage Renal Disease <input type="checkbox"/> Disabled				
Child/Dependent?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare Number If Yes: __ - __ - ____ - ____	Hosp. Eff. Date (Part A) __ / __ / __	Med. Eff. Date (Part B) __ / __ / __
Reason for Entitlement: <input type="checkbox"/> Age 65 or older <input type="checkbox"/> End Stage Renal Disease <input type="checkbox"/> Disabled				

## 7 OTHER HEALTH INSURANCE INFORMATION

**IF YOU HAVE OTHER HEALTH INSURANCE COVERAGE, FAILURE TO COMPLETE THIS SECTION WILL CAUSE SIGNIFICANT DELAYS IN PROCESSING ANY CLAIMS SUBMITTED.**

Is any person listed on the enrollment form covered by another health care plan, HMO, or Medicare?  Yes  No

If yes, will this coverage be continued?  Yes  No If no, please provide the cancellation date \_\_\_/\_\_\_/\_\_\_

Policyholder's Name	Phone Number of Other Insurer ( ) - - - - -	Date of Birth ___/___/___
Name and Address of Insurance Company		

Policy Number	Termination Date ___/___/___	Policy Covers <input type="checkbox"/> Policyholder Only <input type="checkbox"/> Two Person <input type="checkbox"/> Family	Effective Date of Policy ___/___/___
Services Covered: <input type="checkbox"/> Hospital Services <input type="checkbox"/> Physician Services <input type="checkbox"/> Major Medical <input type="checkbox"/> Drug Program <input type="checkbox"/> Dental Services <input type="checkbox"/> Eye/Vision Care Services <input type="checkbox"/> HMO			

Does this policy cover you?  Yes  No Your spouse?  Yes  No Your children?  Yes  No

Please list name(s) of children covered \_\_\_\_\_

Is this coverage under COBRA?  Yes  No If yes, reason for cancellation \_\_\_\_\_

Cancellation Date \_\_\_/\_\_\_/\_\_\_

**READ CAREFULLY, THIS APPLICATION, WHEN ACCEPTED, IS PART OF THE CONTRACT.**

I hereby apply, on behalf of myself and each dependent listed above for the health coverage indicated. If this application is accepted, coverage will be provided according to the terms and conditions of the Health Benefit Plan between CareFirst BlueChoice and myself. I agree to be bound by that Health Benefit Plan of which this application will become part. I also agree to pay current and future subscription charges for the health care coverage provided.

I hereby authorize any physician, hospital or other provider of services to furnish any information, reports, or copies of records, related to care or services rendered to me or any of the dependents listed above, to CareFirst BlueChoice. Such information is to be held confidential.

**I have carefully read this application and agree to its terms. The recorded answers on this application are, to the best of my knowledge and belief, full, complete and true as of this date.**

**THIS INFORMATION IS SUBJECT TO VERIFICATION. FAILURE TO COMPLETE ANY SECTION MAY DELAY CLAIMS PAYMENT.**

**If you have any questions concerning the benefits and services that are provided by or excluded under terms and agreement, please contact a membership services representative before signing this application or card.**

_____ Subscriber's Signature	___/___/___ Date	_____ Dependent's Signature	___/___/___ Date
_____ Authorization Signature	___/___/___ Date		